Testimony of
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Before the
House Ways and Means Subcommittee on Health
Hearing on
Medicare Institutional Providers: Acute and Post-Acute Care
May 15, 2007

Chairman Stark, Mr. Camp, distinguished members of the Committee, thank you for inviting me here today to discuss Medicare's payment systems and payment updates for acute and post-acute care providers. The Centers for Medicare & Medicaid Services (CMS) looks forward to working with Congress in the coming year to build on our efforts to reform Medicare's fee-for-service payment systems and to work towards the shared goal of delivering the highest quality care to Medicare beneficiaries.

As the President's Fiscal Year (FY) 2008 Budget proposals and recent rulemaking efforts demonstrate, CMS is committed to ensuring that Medicare providers are paid appropriately for services furnished to Medicare beneficiaries, that Medicare beneficiaries have access to high-quality care in the most appropriate setting, and that Medicare's payment systems encourage the efficient delivery of quality care. My testimony will offer specific highlights from the President's FY 2008 Budget, and will then summarize our recent rulemaking efforts in the areas of hospitals, long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies.

President's Fiscal Year 2008 Budget Proposals

Federal Reserve Chairman Ben Bernanke, the Medicare Trustees, and the Medicare Payment Advisory Commission (MedPAC) have all stressed the importance of taking immediate action to ensure the long-term sustainability of the Medicare program. Recognizing the gravity of these warnings, the President's Budget proposes to strengthen the Medicare program by encouraging provider efficiency and productivity.

When combined with Medicare administrative proposals,[1] the FY 2008 Medicare legislative proposals included in the Budget would save $5.3 billion in FY 2008 and $75.9 billion over five years.[2] Among other things, the President's Budget would:

- Foster Productivity and Efficiency: By encouraging provider productivity and efficiency through payment adjustments, the Budget would slow cost growth;

- Encourage High Quality Care: The Budget would encourage high quality care by linking payment to the reporting of quality data, expanding on value-based purchasing for hospitals, and eliminating Medicare payment for never events;

- Improve Program Integrity: The Budget would improve program integrity by facilitating the proper coordination of benefits through improved data sharing, creating incentives for providers to recoup their debts, and strengthening the integrity of the administrative appeals process by limiting Mandamus jurisdiction as a basis for obtaining judicial review.

In addition to the proposals in the President's FY 2008 Budget, CMS remains committed to its core mission of encouraging continuous quality improvement across all of Medicare's payment systems. The policies included in the various proposed and final rules this year reflect CMS' efforts to ensure that all Medicare providers have incentives to furnish high quality, efficient care to beneficiaries and that Medicare pays appropriately for those services.

[1] The Medicare budget assumes administrative savings of $1.0 billion in FY 2008 and $10.2 billion over five years. Savings will result from new efforts to strengthen program integrity in Medicare payment systems, correct for inappropriate provider payments, and adjust payments to encourage efficiency and productivity.

[2] The savings estimates are net of a proposal in which Medicare funds are transferred to Medicaid to pay premiums for certain low-income individuals.

Fiscal Year 2008 Hospital Inpatient Prospective Payment System Proposed Rule

The proposed rule to update the FY 2008 hospital inpatient prospective payment system (IPPS) is estimated to increase payments to more than 3,500 acute care hospitals by $3.3 billion. The proposed rule also takes significant steps to improve payment accuracy, while providing additional incentives for hospitals to engage in quality improvement efforts. Reforms include proposals to restructure the inpatient diagnosis related groups (DRGs) to more accurately account for patient severity, ensure that Medicare no longer pays hospitals for the additional costs of hospital-acquired conditions (including infections), and expand the list of publicly reported quality measures.

These proposed reforms continue our efforts, for the third consecutive year, to implement the most significant revision of Medicare's IPPS since 1983. They are measured steps to improve the accuracy of Medicare's payment for inpatient stays to better account for the severity of the patient's condition. They continue changes begun last year to improve the accuracy of Medicare's inpatient hospital payments by using hospital costs rather than charges to set rates. They adjust payment under the IPPS to better recognize severity of illness and the cost of treating Medicare patients by increasing payment for some services and decreasing payment for others. They also will help eliminate biases in the current system that provide incentives for physician-owned specialty hospitals to treat the healthiest and most profitable cases, leaving the sickest and more costly patients to be treated in general acute care hospitals.

Specifically, the proposed rule would create 745 new severity-adjusted diagnosis related groups (Medicare Severity DRGs or MS-DRGs) to replace the current 538 DRGs. The proposed revisions to the current DRG system will continue to be based upon a non-proprietary case mix system that is available to the public. Furthermore, the new DRG system will be a budget neutral change to Medicare's IPPS payments. Overall spending under the MS-DRGs is not projected to differ from payments under the current system. However, payments would increase for hospitals serving more severely ill patients and decrease for hospitals serving patients who are less severely ill.

The new DRG system presents opportunities to change documentation and coding practices to receive higher payments without a real increase in patient severity of illness. Without an adjustment to the IPPS rates to account for this case mix growth, the proposed MS-DRGs would not be budget neutral as required by statute. The CMS Office of the Actuary estimates that an adjustment of 2.4 percent to the IPPS rates for both FY 2008 and FY 2009 will be necessary to account for the anticipated improvements in coding and documentation. CMS will revisit these adjustments in two years if projected and actual data are different.

Prior to FY 2007, the DRG relative weights were based on hospital charges. Basing DRG relative weights on costs instead of charges improves the accuracy of payments, leading to better incentives for hospital quality and efficiency and ensuring that payment rates relate more closely to patient resource needs. In FY 2007, CMS adopted cost weights using hospital data for 13 separate departments over a 3-year transition period. The proposed rule for FY 2008 would continue to phase-in this change to better align payment with the costs of care by using estimated hospital costs, rather than charges, to establish relative weights for the DRGs. Under the proposed rule, hospitals would be paid during FY 2008 based on a blend of one-third charge-based weights and two-thirds cost-based weights for the DRGs. In FY 2009, hospitals would be paid based on 100 percent cost-based DRG weights.

Under the statute, in addition to the base payment for the DRGs, Medicare makes a supplemental outlier payment to a hospital if the estimated costs for treating a particular case exceed the usual Medicare payment for that case by a set threshold. Medicare sets the threshold for high-cost cases at an amount projected to ensure that total outlier payments equal 5.1 percent of total inpatient hospital payments. For FY 2008, CMS is proposing to adopt a high-cost outlier threshold of $23,015, down from $24,475 in FY 2007. CMS is proposing to lower the outlier threshold because fewer cases will be paid as outliers under the revised DRG system, which will more accurately account for patient severity. With the lower threshold, however, CMS projects that it will continue to pay between 5 and 6 percent of total IPPS payments as outliers, as required by law.

In keeping with the Agency's commitment to health care quality, the proposed rule would implement a provision of the Deficit Reduction Act of 2005 (DRA) that takes the first steps toward preventing Medicare from paying hospitals more for the additional costs of treating a patient that acquires a condition (including an infection) during a hospital stay. The DRA requires hospitals to begin reporting secondary diagnoses that are present on a patient's admission, beginning for discharges on or after October 1, 2007. The DRA also requires the Secretary of Health and Human Services (HHS) to select at least two conditions that are (1) high cost, high volume or both; (2) assigned to a higher paying DRG when present as a secondary diagnosis; and (3) are reasonably preventable through application of evidence-based guidelines. Beginning in FY 2009, cases with these conditions would not be paid at a higher DRG unless they were present on admission. The proposed rule identifies six conditions, including three serious preventable events (sometimes called "never events"), that meet the statutory criteria for payment adjustment in FY 2009. CMS seeks public comment on seven additional conditions that could be considered for future years.

The proposed rule recommends changes to the way Medicare pays for hospital capital-related costs based on an analysis that showed substantial positive margins experienced by some hospitals. The rule recommends a full capital payment update for rural hospitals and no update for urban hospitals. The rule also proposes to eliminate the large urban add-on payment and seeks comment on gradually discontinuing the teaching and disproportionate share (DSH) adjustments to capital payments.

In the FY 2007 IPPS and the CY 2007 hospital outpatient prospective payment system (OPPS) final rules, consistent with requirements in the DRA for CMS to expand the "starter set" of 10 quality measures that have been used since 2003, CMS added new measures to the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. The FY 2008 IPPS proposed rule continues the effort by proposing to add five new quality measures, bringing to 32 the number of measures that hospitals would need to report in FY 2008 to qualify for the full market basket update in

FY 2009. The five additional proposed measures include 30-day mortality for Medicare patients with pneumonia, and four measures relating to surgical care improvement. The proposed rule also seeks public comment concerning other measures that could be added for FY 2009 and beyond. In addition to this expansion of inpatient quality measures, the CY 2007 OPPS final rule announced plans to extend quality reporting to outpatient hospitals. Payment rate increases in the outpatient setting will be tied to the reporting of quality measures beginning in 2009. CMS plans to develop quality measures that are specifically appropriate for hospital outpatient care to promote greater value in the purchase of hospital outpatient services for Medicare beneficiaries. As required in section 109 of the Tax Relief and Health Care Act of 2006 (TRHCA), for hospitals that do not submit data on quality measures, the outpatient department fee schedule increase factor will be reduced by two percentage points beginning in 2009.

Finally, to foster transparency and patient safety, CMS is proposing to create new disclosure requirements for specialty hospitals. Physician-owned facilities would have to disclose such ownership to patients and provide the names of the physician owners upon request. Physician-owners who are members of the hospital's medical staff would also be required to disclose their ownership to the patients they refer to the hospital at the time of referral. CMS would have the authority to terminate a provider agreement for noncompliance with these disclosure requirements. In addition, the proposed rule would require a hospital to notify all patients in writing if a doctor of medicine or doctor of osteopathy is not present in the hospital 24 hours a day, seven days per week, and describe how the hospital will meet the medical needs of a patient who develops an emergency condition while no doctor is on site.

Rate Year 2008 Final Rule for Long-Term Care Hospitals

The final rule to update the payment rates and policies for the long-term care hospital prospective payment system (LTCH PPS) for the 2008 Rate Year (RY) assures appropriate payment for services furnished to severely ill patients and patients with medically complex conditions, while providing incentives to long-term care hospitals

(LTCHs) to furnish more efficient care to Medicare beneficiaries. Total Medicare payments to LTCHs in RY 2008 are expected to exceed $4 billion.

LTCHs are generally defined as hospitals that have an average Medicare inpatient length of stay of greater than 25 days. These hospitals typically provide extended medical and rehabilitative care for patients who may suffer from multiple acute or chronic conditions or require clinically complex care. Services typically include respiratory therapy and management of complex medical and post-surgical patients who have had prolonged illnesses.

Implemented in FY 2003 and updated annually, the LTCH PPS sets Medicare reimbursement for approximately 400 LTCHs. CMS is updating the LTCH PPS Federal rate by 0.71 percent to $38,356.45 for patient discharges occurring on or after July 1, 2007 through June 30, 2008. This update is based on the most recent estimate of the market basket applicable to LTCHs, which is 3.2 percent for RY 2008, and the most recently available LTCH case-mix data. CMS analysis of LTCH claims data indicates that a significant portion of the estimated increase in observed case mix between FY 2004 and FY 2005 is due to changes in coding practices and documentation rather than the treatment of more resource intensive patients. CMS, therefore, is adjusting the Federal rate for the estimated 2.49 percent increase in apparent case mix due to changes in coding practices.

Similar to the outlier policy under the IPPS, Medicare pays LTCHs an additional amount for treating unusually high-cost cases. To be eligible for outlier payments, the hospital's estimated costs in treating a given case must exceed the long-term care diagnosis-related group (LTC-DRG) payment by an outlier fixed-loss amount. For RY 2008, that fixed-loss amount is set at $22,954 – up from $14,887 the year before. The revision ensures that estimated aggregate outlier payments do not exceed 8 percent of estimated total payments under the LTCH PPS.

Because the LTC-DRGs are the same DRGs used under the IPPS, although weighted to reflect the greater complexity of LTCH cases, and these refinements would improve the recognition of severity of illness among LTCH patients, CMS has proposed to adopt the same DRG refinements proposed in the FY 2008 IPPS proposed rule for acute care hospitals paid under the IPPS for LTCHs as well. If adopted, these changes will take effect under both payments systems on October 1, 2007.

In the LTCH PPS final rule for RY 2008, CMS is extending the "25 percent rule", which currently applies a payment adjustment only to LTCHs and satellite facilities of LTCHs that discharge patients that were admitted from their co-located host hospital (generally an acute care hospital). The RY 2008 final rule provides for application of the payment adjustment to LTCHs and satellites of LTCHs (including grandfathered facilities) that admit patients from referring hospitals that are not co-located with them and that cause the LTCH or LTCH satellite to exceed a specific threshold of discharges admitted from that referring hospital. It also provides for a similar payment adjustment for grandfathered LTCH hospitals-within-hospitals and LTCH satellite facilities that admit patients from hospitals that are co-located with them. The rule also provides a 3-year transition period for the implementation of these provisions. In the first year of the transition the threshold may not exceed 75 percent. During the transition period, CMS will continue to explore implementing a recommendation from MedPAC to develop facility and patient-level criteria for LTCHs. In 2004, CMS contracted with RTI to perform a comprehensive analysis of the feasibility of developing assessment criteria. CMS is reviewing and evaluating the recommendations made by RTI in their final report, and will continue to engage interested parties in the possible development of a tool to assist in identifying patients that would be better suited to receive treatment in a LTCH setting.

Finally, CMS is revising the current payment adjustment formula as it applies to short-stay outlier discharges from a LTCH that have a length of stay (LOS) that is less than or equal to an "IPPS-comparable threshold." Beginning with discharges on or after July 1, 2007, Medicare will pay for these discharges with an LTCH PPS amount not to exceed

the "comparable IPPS per diem amount" for that particular DRG. This approach will result in appropriate Medicare payments for those cases that are admitted and treated at LTCHs, but that have a LOS similar to cases typically treated in acute care hospitals paid under the IPPS. For short-stay outlier cases where the length of stay exceeds the "IPPS-comparable threshold," payment would be made under the existing short-stay outlier policy.

Fiscal Year 2008 Proposed Rule for Inpatient Rehabilitation Facilities

After an illness, injury, or surgical care, some patients need intensive rehabilitation services, such as physical, occupational, or speech therapy. Inpatient rehabilitation facilities (IRFs) are designed to offer specialized rehabilitative care to patients with the most intensive needs and Medicare pays IRFs at a higher rate than some other hospitals in recognition of this.

In FY 2008, Medicare will pay approximately $6.3 billion to more than 1,200 IRFs. The FY 2008 proposed rule to update payments under the IRF prospective payment system (IRF PPS) would increase Medicare payments to IRFs by approximately $150 million. This includes a 3.3 percent payment increase, based on the rehabilitation, psychiatric and long-term care hospital (RPL) market basket. The RPL market basket is designed to capture inflation in the costs of goods and services required to provide the specialized services offered by these facilities, similar to the market basket that applies to general acute care hospitals.

The classification criterion—also known as the "75 percent rule"—used to classify a hospital or hospital unit as an IRF that is subject to the IRF PPS was determined through consultation with the industry and adopted through the rule-making process. Initially adopted in 1983 to distinguish those hospitals and hospital units that would be eligible for exemption from the IPPS, this classification criterion continues to be applied to distinguish IRFs from acute care hospitals by ensuring that a minimum percentage of a facility's total inpatient population is composed of patients who require intensive rehabilitative services for the treatment of at least one of thirteen medical conditions

specified in regulations. This minimum percentage is known as the compliance threshold. CMS's intent in adopting the 75 percent rule was to protect patient access to care by providing IRFs with some flexibility when admitting patients. As long as the required percentage of a facility's total inpatient population require intensive rehabilitative services for at least one of the 13 specified medical conditions specified in the regulations, the facility can maintain its status as an IRF and have the flexibility to offer their highly specialized services to patients who do not meet those specified conditions. During the transition period provided for in the regulations, a comorbidity meeting conditions specified in the regulations may also be counted toward the applicable threshold.

As enforcement of the 75 percent rule gradually phases in from July 1, 2004 through July 1, 2008, Medicare claims data have demonstrated that patients – who might have been treated in an IRF (but who have clinical conditions appropriate for care outside of an IRF) – are now getting needed care in other more appropriate and less costly settings. Accordingly, the FY 2008 IRF PPS proposed rule does not change the phase-in to the full 75 percent compliance threshold as the appropriate threshold that maintains an IRF's flexibility in admitting patients, while ensuring that care is delivered in the most appropriate setting.

The 75 percent compliance threshold is being phased in according to the following methodology. CMS uses the start of a provider's cost reporting period to determine which compliance threshold to apply to determine if a hospital should be classified as an IRF. For example, in accordance with Section 5005 of the Deficit Reduction Act of 2005 (DRA), a 60 percent threshold applies for cost reporting periods beginning during the 12-month period beginning on July 1, 2006. The compliance threshold increases to 65 percent for cost reporting periods beginning during the 12-month period beginning on July 1, 2007. For cost reporting periods beginning on and after July 1, 2008, the compliance threshold is 75 percent.

For the cost reporting periods that begin before July 1, 2008, the 75 percent rule regulations allow co-morbidities that meet the regulatory criteria to be used to determine the compliance percentage. This transitional provision expires for cost reporting periods that will begin on or after July 1, 2008. The proposed rule does not extend its application, but CMS is soliciting comments and research on current policy or other options, including extending this provision for a specified time or making it a permanent part of the IRF PPS policy.

In addition, the proposed rule would increase the high-cost outlier threshold to $7,522 from $5,534 in FY 2007, based on an analysis of 2005 data which indicates that the proposed threshold would maintain estimated outlier payments at 3 percent of total payments under the IRF PPS. Although the higher threshold would mean that fewer cases would qualify for outlier payments, a lower outlier threshold would require an across-the-board reduction in the base payment for an IRF stay in order to maintain budget neutrality. The high-cost outlier threshold may be updated for the final rule based on analysis of 2006 data. The proposed rule would also clarify that short-stay transfer cases that meet the criteria to qualify for outlier payments are eligible to receive the additional payments.

Fiscal Year 2008 Proposed Rule for Skilled Nursing Facilities

Under the FY 2008 proposed rule to update the skilled nursing facility prospective payment system (SNF PPS), Medicare payments to skilled nursing facilities (SNFs) would increase by approximately $690 million. This 3.3 percent increase reflects CMS' commitment to improving the quality of care in the long-term care setting while maintaining predictability and stability in payments for the nursing home industry. The new proposed payment rates also continue to include a special adjustment to cover the additional services required by nursing home residents with HIV/AIDS.

CMS uses a SNF market basket to measure changes in the prices of an appropriate mix of goods and services included in covered SNF stays. The price of items in the SNF market basket is measured each year, and Medicare payments are adjusted accordingly. The

proposed rule includes a proposal to update the SNF market basket, which currently reflects FY 1997 data, to reflect FY 2004 data. Other proposed revisions include updating the SNF market basket inputs, using Medicare allowable total cost data (rather than total facility cost data) to derive the SNF market basket cost weights, and creating two new cost categories: professional liability insurance and postage.

To help distinguish between major forecast errors and more typical minor variances, the proposed rule would revise the threshold for the difference between the forecasted and actual change in the market basket triggering a forecast error adjustment from the current 0.25 percentage point threshold to 0.5 percentage point, effective with FY 2008.

Calendar Year 2008 Proposed Rule for Home Health

Under the CY 2008 proposed rule to update the home health prospective payment system (HH PPS), payments to home health agencies (HHAs) would increase by an estimated $140 million. This proposed rule reflects CMS' commitment to ensuring more appropriate payment for services provided by Medicare HHAs, while establishing incentives for more efficient care for Medicare beneficiaries.

The proposed rule increases the home health market basket by 2.9 percent. It also contains a provision to continue to adjust payment for the reporting of quality data. HHAs that submit the required quality data would receive payments based on the proposed update of 2.9 percent for CY 2008. HHAs that do not submit quality data would have their increase reduced by 2 percentage points to 0.9 percent for CY 2008. Additionally, CMS analysis of claims data indicates that a significant portion of the recent increase in observed case mix is due to changes in coding practices and documentation rather than treatment of more resource intensive patients, and this rule proposes to reduce the national standardized 60-day episode payment rate by 2.75 percent per year for three years beginning in CY 2008 to account for these changes in case-mix that is not related to a home health patient's actual clinical condition.

In addition, this proposed rule includes the first proposed refinements to the HH PPS since the inception of the payment system. These proposed refinements would improve the comprehensiveness of the case-mix model in the HHS PPS and thus improve the accuracy of Medicare's payments. One example is a proposal to replace the current therapy threshold at 10 visits with three new therapy thresholds at six, 14, and 20 therapy visits. These changes would significantly increase the case-mix model's ability to more appropriately reflect HHA costs and consequently provide more accurate payments to HHAs. In addition, in response to ongoing concerns about the inadequacy of the current payment for non-routine medical supplies under the HH PPS, the rule proposes to replace the existing approach with a system that pays for non-routine medical supplies adjusted for a patient's severity.

Post-Acute Care Payment Demonstration

As discussed above, Medicare currently covers post-acute care services in a variety of settings, including long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities and home health agencies. Medicare's post-acute care benefits and payment policies currently focus on the site of service instead of the characteristics and needs of the particular beneficiary. As a result, payments across settings may differ considerably even though the clinical characteristics of the beneficiary and the services delivered are very similar.

Section 5008 of the DRA authorizes a post-acute care payment reform demonstration, requiring the Secretary to establish a demonstration program by January 1, 2008 that would use a comprehensive assessment tool at hospital discharge to determine appropriate post-acute care placement based on patient care needs and other characteristics. Under the demonstration, a standardized patient assessment instrument will be used. This instrument referred to as CARE (Continuity Assessment Record & Evaluation) will be comprehensive, interoperable and implemented on a secure internet based platform, with the objective of enhancing beneficiaries' safety with transfers between settings and deliver critical health care information to providers in real time.

Conclusion

Mr. Chairman, thank you again for the opportunity to appear before you today. CMS is firmly committed to implementing rational, responsible, and sustainable policies to ensure the fiscal sustainability of the Medicare program. Our actions now will directly impact our ability to preserve the promise of health care coverage for America's seniors, people with disabilities, and low-income, vulnerable populations. We look forward to working with Congress in the coming year to build on our efforts to administratively reform Medicare's fee-for-service payment systems – including those that impact the institutional providers we are discussing today.

I would be happy to answer any questions at this time.